

UPMC Health Plan

BOTOX, MYOBLOC, DYSPORT, AND XEOMIN

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services.

Otherwise, please return the completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.

Please complete all sections of this form AND include details of past relevant medical treatment that substantiates the need for an exception to using formulary alternatives (e.g., past prescription treatment failures, documented side effects, chart documentation, lab values, etc.). Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:

Patient Name:		Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
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Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic		Strength:	Frequency:	Qty. Dispensed:
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Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New Medication	If ongoing, provide date started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing Medication			<input type="checkbox"/> No

Please indicate place of administration:	<input type="checkbox"/> Physician Office	Will the drug be: (select one)
	<input type="checkbox"/> Hospital/Clinic	
	<input type="checkbox"/> Patient Home	<input type="checkbox"/> Billed directly by the provider via JCODE
Please provide hospital/facility name and address:		JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

Please indicate the diagnosis on the left and complete the corresponding questions.

<input type="checkbox"/> Hyperhidrosis	Has the member tried and failed 10-20% topical aluminum chloride?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the prescribing physician a dermatologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Migraine Headache	Does the member have headaches occurring on 15 or more days a month for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are 8 or more of the total headache days per month considered migraine or probable migraine days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have greater than 4 distinct headache episodes, each lasting 4 hours a day or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the member using opioids for greater than 10 days per month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Overactive Bladder (with urgency, urge incontinence, and frequency)	Is the prescribing physician a urologist or fellowship-trained urogynecologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have there been greater than 3 urinary urgency incontinence episodes in a 3-day period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have there been greater than 8 micturitions per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the member tried and failed behavioral therapy (such as weight loss, dietary changes, exercise)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide chart documentation showing specific examples of how quality of life is impacted.	<input type="checkbox"/> Included <input type="checkbox"/> Not available
<input type="checkbox"/> Other (Please Specify)		

History of other medications used to treat the above condition

(Specific clinical information is essential to determine whether this medication can be approved.)

Medication Trial/ Previous Therapy	Date of Therapy Start Date End Date	Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing

Please provide any additional information that should be considered in the space below: